

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03924

CERTIFICATE OF DEATH

03922

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph M Regan		4. DATE OF DEATH Month March Day 16 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1900
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		12. KIND OF BUSINESS OR INDUSTRY D. C. Government	
13. FATHER'S NAME Timothy B. Regan		14. MOTHER'S MAIDEN NAME Johanna Regan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 577-07-9967	
17. INFORMANT Mrs. Mildred O. Regan		18. ADDRESS 1009 Nora Drive Silver Spring, Md.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) 2		INTERVAL BETWEEN ONSET AND DEATH 3-4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/30/66 to 16 March 1967 , that (I) (we) last saw the deceased alive on 12/30/66 and that death occurred on 15 March 1967 from causes and on the date stated above			
22a. SIGNATURE William D. Aud M.D.		22b. DATE SIGNED 3/16/67	
22c. PHYSICIAN'S NAME (Type) WILLIAM D. AUD		22d. ADDRESS 9006 COLESVILLE RD S.S. MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 20, 1967	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION (City or Town) (County) (State) Silver Spring Montg. Md.
24. FUNERAL DIRECTOR J. B. Thomas Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR MAR 22 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03925

CERTIFICATE OF DEATH

03923

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church 83-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		d. STREET ADDRESS 2206 Pimmit Drive	
3. NAME OF DECEASED (Type or print) First Margaret Middle Lynne Last Rice		4. DATE OF DEATH Month March Day 10 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 February 1944
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jay C. Rayner		14. MOTHER'S MAIDEN NAME Margaret Woods	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Record		18. ADDRESS The Clinical Center, Bethesda, Maryland 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas Septicemia INTERVAL BETWEEN ONSET AND DEATH 24 Hours DUE TO (b) Perirectal Abscess 24 Hours DUE TO (c) Acute Lymphocytic Leukemia 18 Months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from March 3 , 19 67 , to March 10 , 19 67 that he (we) last saw the deceased alive on March 10 , 19 67 , and that death occurred at 3:40 M , from causes and on the date stated above.			
22a. SIGNATURE Jerry L. Spivak		22b. DATE SIGNED 11 March 1967	
22c. PHYSICIAN'S NAME (Type) Jerry L. Spivak, MD.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 14, 1967	23c. NAME OF CEMETERY OR CREMATORY Sparta Presbyterian	23d. LOCATION (City or Town) (County) (State) Sparta, New Jersey
24. FUNERAL DIRECTOR Clark E. Warner		25a. REC'D BY REGISTRAR MAR 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 8434 Georgia Avenue Silver Spring, Md.	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03926

CERTIFICATE OF DEATH

03924

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda,</u> <u>15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4977 Battery Lane Apt. 421</u>	
3. NAME OF DECEASED (Type or print) <u>First Ruth Middle Jones Last Richards</u>		4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>16-16-05</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Josiah Walters Jones</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Sherman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>151-34-7374</u>	
17. INFORMANT <u>James A. Richards -son-</u>		Address <u>Rockville, Maryland</u> <u>1620 Burriss Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2041 Deepened Anemia</u> DUE TO (b) <u>Myelogenous Leucemia</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-23-</u> , <u>1965</u> , to <u>3-20-</u> , <u>1967</u> , that (I) (we) last saw the deceased alive on <u>3-19</u> , <u>1967</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>W. T. Joyce</u>		22b. DATE SIGNED <u>3-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. T. Joyce</u>		22d. ADDRESS <u>4977 Battery Lane Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>3/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George co. Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home Rockville, Mar 1</u>		25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ASUSO

INSTRUMENT OF DEED

ASUSO

RECORDED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA, IN THE CITY OF WASHINGTON, THIS 10TH DAY OF MARCH, 1904, AT 10 O'CLOCK A.M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03927 CERTIFICATE OF DEATH 03925										
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE D.C. b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA					c. LENGTH OF STAY IN 1b 5 DAYS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bethesda - Silver Springs N. H.					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WASHINGTON 47-3					
d. STREET ADDRESS 935 15TH ST. SE.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First ERNESTINE Middle ROBERTSON Last			4. DATE OF DEATH Month March Day 24 Year 1967				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-13-1891		9. AGE (in years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME ERNEST SEBOLD					14. MOTHER'S MAIDEN NAME EDNA JOHNSON HENNECKE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT VIRGINIA HAUSSLER		Address 46 OLD MILL RD MANHASSET, N.Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Suspected colonic malignancy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myeloid metaplasia								INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July , 19 65 , to March 24 , 19 67 , that (I) (we) last saw the deceased alive on March 17 , 19 67 , and that death occurred at 9A M, from the causes and on the date stated above.										
22a. SIGNATURE Richard Kaufman					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Mar 24, 1967			
22c. PHYSICIAN'S NAME (Type) RICHARD KAUFMAN					22d. ADDRESS 916 19th St. NW Wash. DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 3-28-67		23c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		23d. LOCATION (City, town or county) (State) WASHINGTON, D.C.			
24. FUNERAL DIRECTOR LEE FUNERAL HOME					ADDRESS 300 4TH ST. N.E. WASH. DC		25a. REC'D BY REGISTRAR 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT

03928

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03926

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
c. LENGTH OF STAY IN 1b 5 DAYS		d. STREET ADDRESS 8207 ROANOKE AVE.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARIUM & HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MR. ABRAHAM		4. DATE OF DEATH MARCH 22 1967	
5. SEX MALE		6. COLOR OR RACE NEGRO	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ? 1887	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARDNER-RETIRED		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME TOM ROBINSON		14. MOTHER'S MAIDEN NAME ISABELLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT PATIENT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) BELDEN R. REAP		22. DATE SIGNED 3/22/1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/25/67	
23c. NAME OF CEMETERY OR CREMATORY Ash Memorial		23d. LOCATION (City or town) (County) (State) Sandy Spring Montg Md.	
24. FUNERAL DIRECTOR Robert L. Snowden		25a. REC'D BY REGISTRAR MAR 30 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03929

CERTIFICATE OF DEATH

03927

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 7424 Bethune Street	
3. NAME OF DECEASED (Type or print) FEKLA Felka Petrovna ROMANENKO		4. DATE OF DEATH Month March Day 4 Year 1967	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1900
9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (County & State, or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Peter KIRIENKO	
14. MOTHER'S MAIDEN NAME Vassa GOOSLOVA		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 116 28 1201		17. INFORMANT Charles C. SPOONER Jr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Cerebral Metastatic Disease DUE TO (b) Secondary to Cancer of Breast DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from Feb. 15, 1967 , to March 4, 1967 , that (X) (we) last saw the deceased alive on March 4, 1967 , and that death occurred at 5:50 PM , from causes and on the date stated above.			
22a. SIGNATURE R. J. Cavanagh		22b. DATE SIGNED 4 March 1967	
22c. PHYSICIAN'S NAME (Type) R. J. CAVANAGH, LT MC USN		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Type) Burial	23b. DATE THEREOF 3/9/67	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR Falls Church Funeral Home		25. REGISTRAR'S SIGNATURE Charles Judge	
26. ADDRESS 1102 W. Broad St., Falls Church, Va.		27. REC'D BY REGISTRAR MAR 8 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03930

CERTIFICATE OF DEATH

03928

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gwendolin</u> First <u>Robert</u> Middle <u>Rotondaro</u> Last <u>Rotondaro</u>		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-18-16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Draftsman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Turner Clinedinst</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Stedman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Carmine Rotondaro</u>		Address <u>11804 Lovejoy Street Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>456X</u> IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>WEGENER'S GRANULOMATOSIS</u> DUE TO (c) <u>4 YEARS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 DAYS POST-OP CRANIOTOMY (WEGENER'S GRANULOMATOSIS)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>AUGUST</u> , 19 <u>67</u> , to <u>MARCH 20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MARCH 20</u> 19 <u>67</u> , and that death occurred at <u>10 A.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward A. Beeman</u>		22b. DATE SIGNED <u>MARCH 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD A. BEEMAN</u>		22d. ADDRESS <u>1015 SPRING ST. SILVER SPRING MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 27 1967</u>	

Medical Certificate
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #23b Film #G387 473767 pc									
03931					03929				
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN TB 24 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY North Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83-3 d. STREET ADDRESS 4864 33rd. Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Joan			First (NMN)		Middle Rowe		4. DATE OF DEATH Month March Day 15 Year 19 67		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1894		9. AGE (In years last birthday) yrs. 72 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Edinburgh, Scotland		12. CITIZEN OF WHAT COUNTRY? Usa	
13. FATHER'S NAME Alexander Dalrymple					14. MOTHER'S MAIDEN NAME Janet Miller				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. 149 05 7739B		17. INFORMANT Julia Rowe 4864 33rd Road Virginia				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Arteriosclerotic cardio-vascular disease (c) INTERVAL BETWEEN ONSET AND DEATH								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 19 , 19 67 , to Mar. 15 , 19 67 that (I) (we) last saw the deceased alive on Mar. 15 , 19 67 , and that death occurred at 11:00 PM from causes and on the date stated above.									
22a. SIGNATURE R. J. Kinney						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 17 March 1967	
22c. PHYSICIAN'S NAME (Type) R. J. KINNEY, M.D.						22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 21, 1967		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.						25a. REC'D BY REGISTRAR MAR 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Virginia

Montgomery

North Arlington

Belmont (Penn)

1954 32nd St

Naval Hospital

March

Rowe

(1954)

Joan

Sept. 1, 1954

James

Jan

Stoughton, Grafton

Hennepin

James Miller

Alexander, Jefferson

North Arlington

1954 32nd St

Hennepin, Minnesota

Attention: Mr. J. J. Kinney

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11 MAR 1954

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10P 10

Naval Hospital, Bethesda, Md.

J. J. Kinney, M.D.

Arlington National

Signal

Robert A. Thompson, Chief of Home

1000 Washington Ave., Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03932

03930

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Travilah		c. LENGTH OF STAY IN 1b 17 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Query Mill Road		d. STREET ADDRESS Query Mill Road	
3. NAME OF DECEASED (Type or print) First REMO Middle RUBINO Last RUBINO		4. DATE OF DEATH Month March 1, Day 19 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1915
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 51 Days 15 Hours 1 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hairdresser		12. KIND OF BUSINESS OR INDUSTRY New Jersey	
13. FATHER'S NAME Antonia Rubino		14. MOTHER'S MAIDEN NAME Ermiria Cernelli	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Wife Evelyn V. Rubino		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Myocardial Infarct. DUE TO (b) Hypertension Arteriosclerotic Heart Dis DUE TO (c) 5 year.		INTERVAL BETWEEN ONSET AND DEATH 5 year.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-24 , 19 67 , to 3-1 , 19 67 , that (I) (we) last saw the deceased alive on 2-22 , 19 67 , and that death occurred at 4:45 A.M., from causes and on the date stated above.			
22a. SIGNATURE Alvin I. Kay		22b. DATE SIGNED 3-1-67	
22c. PHYSICIAN'S NAME (Type) ALVIN I. KAY		22d. ADDRESS 1835 I Street, N. W. Washington, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-2-67	23c. NAME OF CEMETERY OR CREMATORY Potomac Cemetery	23d. LOCATION (City or Town) (County) (State) Potomac, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.		25. REC'D BY REGISTRAR MAR 8 1967	
26. REGISTRAR'S SIGNATURE J. Charles Judge			

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Form with multiple sections and fields, including a large circular stamp on the left side. The text is mostly illegible due to fading and bleed-through.

Vertical text on the right margin, possibly a page number or reference code.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03933 **CERTIFICATE OF DEATH** **03931**

1. PLACE OF DEATH a. CDUNITY MONTGOMERY MARYLAND b. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC 20016 c. LENGTH OF STAY IN 1b 10 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6102 MASS. AVE.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) Washington DC 20016 d. STREET ADDRESS 6102 MASS. AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BESSIE First RUBINSTEIN Last		4. DATE OF DEATH March 30 Month 1967 Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR 16, 1881
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR: Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (County & State, or foreign country) BESSARABIA, ROMANIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME SHEPSI MENDEL BALAN		14. MOTHER'S MAIDEN NAME CHANA RUCHEL WAX	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-24-1313	
17. INFORMANT MRS. IDA SHERMAN Address 6102 MASS. DC 20016			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 coronary heart disease DUE TO (b) generalized arteriosclerosis DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 7, 1967 to Mar 30, 1967 , that (I) (we) last saw the deceased alive on Mar 30, 1967 , and that death occurred at 5:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE M. van Kinsbergen		22b. DATE SIGNED 3-30-67	
22c. PHYSICIAN'S NAME (Type) DR. M. VAN KINSBERGEN		22d. ADDRESS 5715 MASS. AV. WASH DC 20016	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/2/67	
23c. NAME OF CEMETERY OR CREMATORY D.C. LODGE CEM.		23d. LOCATION (City, town or county) (State) WASH. D.C.	
24. FUNERAL DIRECTOR GOLDBERG FUNERAL HOME		25a. REC'D BY REGISTRAR APR 4 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria	
c. LENGTH OF STAY IN 1b 74 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		d. STREET ADDRESS 4918 Celtic Drive, Apt. 101	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edith Middle Elizabeth Last Rush		4. DATE OF DEATH Month March Day 17 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 May 1897	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harry W. Honan		14. MOTHER'S MAIDEN NAME Louise Plumley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not Available		17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO (b) Intestinal Obstruction DUE TO (c) Metastatic malignant carcinoid					INTERVAL BETWEEN ONSET AND DEATH 2 minutes 3 weeks 20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2 January, 1967, to 17 March, 1967 , that <input checked="" type="checkbox"/> (we) saw the deceased alive on 17 March 1967 , and that death occurred at 1:45A.M. from causes and on the date stated above					
22a. SIGNATURE John P. Kokko		22b. DATE SIGNED 17 March 1967		22c. PHYSICIAN'S NAME (Type) John P. Kokko	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/21/67	23c. NAME OF CEMETERY OR CREMATORY St. Michaels	23d. LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR 1500 W. Braddock Rd. Alexandria, Va.			25. RECEIVED BY REGISTRAR MAR 21 1967	26. REGISTRAR'S SIGNATURE [Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03935

03933

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda D.O.A.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>11-N. Cherry Grove Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Calvin Russell</u>				4. DATE OF DEATH <u>March 22</u> 19 <u>67</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/27/46</u>	
9. AGE (In years last birthday) <u>20</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Mason Russell</u>		14. MOTHER'S MAIDEN NAME <u>Uada Trumpower</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>CHARLES M. RUSSELL #2</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Injuries multiple and severe</u> 8234 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auto accident</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lost control of car left highway hit steel light pole</u>			
20c. TIME OF INJURY Month, Day, Year <u>9 30 a.m. 3/22 1967</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
20f. (City or town) <u>Bethesda Montgomery Md</u>				20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>				22. DATE SIGNED <u>3/23/67</u>			
EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR 25 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST CEM</u>		23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR-SON ANNAPOLIS MD.</u>				25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03033

03033

20

Charles M. Russell 95

lost control of the engine and crashed

at 3:15 PM. The engine was running at 1500 RPM.

John A. Baker

John A. Baker, 1961 Buick Wildcat, 1961 Buick Wildcat, 1961 Buick Wildcat

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Medical Certification
Cleared by Medical Examiner 3/19/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03936

CERTIFICATE OF DEATH

03934

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>609 McNeill</u>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>M</u> Last <u>RYAN</u>		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-83</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Post Office Dept</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MASS.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Thompson</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Richardson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>215-44-4169T</u>		17. INFORMANT <u>Mrs. Bertha R. May (same as #2)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon & Metastases</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>8-10 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Decompensation</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>1955 to 19 March 1967</u> that (I) (we) last saw the deceased alive on <u>11 March 1967</u> , and that death occurred at <u>10:40 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>William D. Aud</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>William D. Aud</u>		22d. ADDRESS <u>9005 Galesville Rd. Sil.Sp. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-22-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____	
24. FUNERAL DIRECTOR <u>COLLINS FUNERAL HOME 3821 14th ST. N.W. D.C.</u>		25a. REC'D BY REGISTRAR <u>MAR 22 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared & Medical Examiner 3/28/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03937

Item #8 Film #G387 4/3/67 pc

CERTIFICATE OF DEATH

03935

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. LENGTH OF STAY IN 1b <u>3/26/67-3/28/67</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyatts Md.</u>		16'2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>8002-14th Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sophie</u> First Middle Last		4. DATE OF DEATH <u>March 28 1967</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1894</u> 9. AGE (In years lost birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>TURNER</u>		14. MOTHER'S MAIDEN NAME <u>TOBY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>HUSBAND</u> Address <u>ISIDORE SACKS - ITEM 2. ABOVE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Congestive heart failure</u> DUE TO (b) <u>Diabetic acidosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>36 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 20, 1966</u> to <u>March 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 28, 1967</u> , and that death occurred at <u>1:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond Bradshaw</u> M.D.		22b. DATE SIGNED <u>3/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw MD</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-29-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BETH ISRAEL CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>WOODBRIIDGE N.J.</u>
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY SONS - WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

728

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03936

03938

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Randolph Hills Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 629 Northwood Terr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) SARAH		First SARAH		Middle SAOLE		Last SAOLE		4. DATE OF DEATH Month 3 Day 31 Year 19 67	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/10/86		9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months ---- Days ----	
13. FATHER'S NAME Samuel Eli Tash		14. MOTHER'S MAIDEN NAME Rebecca Katz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ----		16. SOCIAL SECURITY NO. ----		17. INFORMANT Mrs. Lewis Goss, 629 Northwood Terr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Essential Hypertension		INTERVAL BETWEEN ONSET AND DEATH 7 days 20 years 25 years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis with Hemiplegia -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----		20f. (City or town) ---- (County) ---- (State) ----	
21. I certify that (I) (the hospital) attended the deceased from Jan. 25, 1967 to March 31, 1967 that (I) (we) last saw the deceased alive on 3/31, 1967 and that death occurred at 10 P.M. from the causes and on the date stated above.		22a. SIGNATURE Samuel Dessoft M.D. 22c. PHYSICIAN'S NAME (Type) SAMUEL DESSOFF		22b. DATE SIGNED APR 4 1967		22d. ADDRESS 1302-18th N.W. WASH. D.C.		22e. REC'D BY REGISTRAR APR 4 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/2/67		23c. NAME OF CEMETERY OR CREMATORY Elesavetgrad Cemetery		23d. LOCATION (City, town or county) Washington, D.C.		23e. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons		24a. ADDRESS N.W., Wash. D.C.		24b. DATE APR 4 1967		24c. REGISTRAR'S SIGNATURE Charles Judge		24d. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03038

1952

Montgomery

Blairland

Silver Spring

629 Northwood Lane

32 1957

10/10/58

Russia

Harold Katz

Miss Lewis Code, 629 Northwood Lane

APR 1 1959

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03939

CERTIFICATE OF DEATH

03937

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda-Silver Spring Nursing Home		d. STREET ADDRESS 4000 Massachusetts Ave., NW	
3. NAME OF DECEASED (Type or print) First Middle Last CARL BRADLEY SALTS		4. DATE OF DEATH Month Day Year 3 20 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-1904
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Salts		14. MOTHER'S MAIDEN NAME Margaret Payne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Gladys M. Salts, Wife, Same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Art Disease DUE TO (c) Severe Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH mins 1958 1955	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Brachyectasis, Diabetes, abd. aneurysm, Gout, Gangrene		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from OCT 19 1959 , to OCT 20 1967 , that (I) (we) last saw the deceased alive on 3/20 1967 , and that death occurred at 2:30 M, from causes and on the date stated above.			
22a. SIGNATURE James R. Nugent		22b. DATE SIGNED 3/20/67	
22c. PHYSICIAN'S NAME (Type) JAMES R. Nugent		22d. ADDRESS 4000 Mass Ave N.W. Wash D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 3/22/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., Washington, DC		25. REC'D BY REGISTRAR MAR 23 1967	
		25a. REGISTRAR'S SIGNATURE Charles Judge	

03333

CERTIFICATE OF DEATH

03333

State of Colorado

Washington

1000 Massachusetts Ave., N.W.

Bedford - Silver Spring, Maryland

Franklin Co., Tenn.

Maryland

Glenn M. Allen, wife, same as above

Executive

Albert Allen

No

Washington, D.C.

John Will Gregory

1933

1933

George Taylor's Sons, Inc., Washington, D.C.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03940

03938

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park Park			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7620 Maple Avenue			d. STREET ADDRESS 7620 Maple Avenue		
3. NAME OF DECEASED (Type or print) First GEORGE Middle EDWIN Last SANDS			4. DATE OF DEATH Pronounced March 10, 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/28/08	9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months 15 Days 1 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Estimator (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Naval Ord. Lab.		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Elizabeth Monmonier, 5129 Rolling Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		M.D. Charles S. Springate, M.D.		22. DATE SIGNED March 10, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/15/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Montgomery Balto. Co. Md.
24. FUNERAL DIRECTOR Howard H. Hubbard			25a. REC'D BY REGISTRAR MAR 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

08832

08832

ATLANTIC EXAMINER'S REPORT IN DEATH

FOR THE
ATLANTIC EXAMINER

ATLANTIC EXAMINER'S REPORT IN DEATH

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ATLANTIC EXAMINER'S REPORT IN DEATH

ATLANTIC EXAMINER'S REPORT IN DEATH

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03941

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03939

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>		d. STREET ADDRESS <u>1013 Ruatan St.</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>a.</u> Middle <u>Saunders</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-17</u> 9. AGE (In years last birthday) <u>49</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>telephone operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CoP telephone Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Gargano</u>		14. MOTHER'S MAIDEN NAME <u>Antoinette Giodano</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>578-03-0862</u>	
17. INFORMANT <u>Roy J. Saunders</u> Address <u>1013 Ruatan Street Adelphi, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency Acute.</u> DUE TO (b) <u>Right Cardiac Failure.</u> DUE TO (c) <u>Hypertensive Cardio Vascular Disease.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 h.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>3/5/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u> <u>7936 Old Georgetown Rd. Bethesda, Maryland</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hyattsville, Maryland</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 8 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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11000

Caribbean Development Authority
P.O. Box 1000, Georgetown, Guyana
Telephone: 222-1111

2/10/17

John D. Ball

1000 Old Georgetown Rd.
Georgetown, Guyana
Telephone: 222-1111

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03942

03940

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home		d. STREET ADDRESS 7906 MacArthur Blvd.	
3. NAME OF DECEASED (Type or print) HUGO SCHMIDT		4. DATE OF DEATH Month Mar. Day 12, Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1900
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Worker		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Franklin County, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE SCHMIDT		14. MOTHER'S MAIDEN NAME MARY KUNTZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO --		16. SOCIAL SECURITY NO. 579-01-2705	
17. INFORMANT Ethel Compton		Address Blacklick 653 N. High St. Ohio	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH 18 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from November, 1965 , to March, 1967 , that (I) (we) last saw the deceased alive on March 11, 1967 , and that death occurred at 3:00 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Hamilton P. Dorman		22b. DATE SIGNED 3-12-67	
22c. PHYSICIAN'S NAME (Type) HAMILTON P. DORMAN		22d. ADDRESS 1302 - 18th St., N. W. Washington, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-16-67	23c. NAME OF CEMETERY OR CREMATORY Potomac Methodist Cem.	23d. LOCATION (City or Town) (County) (State) Potomac, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03240

LETTER TO THE DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03943

CERTIFICATE OF DEATH

03941

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 1173	
c. LENGTH OF STAY IN 1b <u>14M 4mos</u>		d. STREET ADDRESS <u>3040 IDAHO AVE., N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL HALL SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HILDA (NMI) SCHWEIZER</u>		4. DATE OF DEATH Month Day Year <u>MARCH 5 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/16/1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>LOUISIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BERNARD SWITZER</u>		14. MOTHER'S MAIDEN NAME <u>FRANNY SCHWARTZCHILD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. MALVINA BALOGH</u>		Address <u>3040 IDAHO AVE., N.W. WASHINGTON, D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, oropharynx</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>cerebral arterial thrombosis</u> (c) <u>ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>4 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>—</u> , to <u>THE PRESENT</u> , that (I) (we) last saw the deceased alive on <u>2-26-1967</u> , and that death occurred at <u>1:00</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. Youngblood</u> M.D.		22b. DATE SIGNED <u>3-5-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD W. YOUNGBLOOD</u>		22d. ADDRESS <u>WASHINGTON CLINIC, WASHINGTON, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>3/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREM.</u>	23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MD.</u>
24. FUNERAL DIRECTOR <u>JOSEPH GAVILER'S SONS, INC.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14950

CERTIFICATE OF DEATH

1900

EDWARD W. YOUNG

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03944

03942

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY - - -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colonial Villa Nursing Home				d. STREET ADDRESS 3701 Connecticut Ave, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last NORA J. SHALLCROSS				4. DATE OF DEATH Month Day Year Mar 29 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-3-1879	
				9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Internal Revenue/ Maryland		11. BIRTHPLACE (County & State, or foreign country) U.S.A.	
13. FATHER'S NAME William H. Rabbitt				14. MOTHER'S MAIDEN NAME Lucy J. Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. - - -		17. INFORMANT Mrs. Outram W. Sherman Address Mahopac, N.Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 CONGESTIVE HEART FAILURE DUE TO (b) Arterio-sclerotic Heart Disease DUE TO (c) 2 weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3-1 , 19 67 , to 3-29 , 19 67 , that (I) (we) last saw the deceased alive on 3-29 , 19 67 , and that death occurred at 6 AM , from causes and on the date stated above.							
22a. SIGNATURE Robert Kramer				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ROBERT KRAMER				22d. ADDRESS 8484 16th ST. S.S. Nd			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-1-1967		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. ve. N.W. Wash. D.C.				25. DATE OF REGISTRATION APR 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MD MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03945

CERTIFICATE OF DEATH

03943

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 79 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fayetteville 85-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, NIH, Bethesda, Md.			d. STREET ADDRESS (No street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Audrey Middle Glendon Last Shockey			4. DATE OF DEATH Month March Day 23 Year 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 September 1908	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
13. FATHER'S NAME Parkinson McClung			14. MOTHER'S MAIDEN NAME Sarah Bragg		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT Address The Medical Records, The Clinical Center, National Institutes of Health, Bethesda, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Agnogenic myeloid metaplasia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 hours 4 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3 January, 19 67 , to 23 March, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 23 March 19 67 , and that death occurred at 12:25 PM from causes and on the date stated above.					
22a. SIGNATURE Martin H. Cohen			22b. DATE SIGNED 24 March 1967		22c. PHYSICIAN'S NAME (Type) Martin H. Cohen, M.D.
23a. BURIAL, CREMATION, REMOVAL (Specify) 3-26-67			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Fayetteville, W Va
24. FUNERAL DIRECTOR Frazier 389 R.I. Ave. NW. Wash. D.C.			25a. REC'D BY REGISTRAR MAR 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

MEDICAL CERTIFICATION

03949

STATE OF TEXAS

1911

COUNTY OF DALLAS	
CITY OF DALLAS	
No. 1000	
Date of Birth	
Place of Birth	
Sex	
Race	
Religion	
Education	
Occupation	
Marital Status	
Name of Spouse	
Date of Marriage	
Name of Children	
Date of Birth of Children	
Name of Parents	
Date of Birth of Parents	
Name of Grandparents	
Date of Birth of Grandparents	
Name of Siblings	
Date of Birth of Siblings	
Name of Uncles	
Date of Birth of Uncles	
Name of Aunts	
Date of Birth of Aunts	
Name of Cousins	
Date of Birth of Cousins	
Name of Nephews	
Date of Birth of Nephews	
Name of Nieces	
Date of Birth of Nieces	
Name of Great-Uncles	
Date of Birth of Great-Uncles	
Name of Great-Aunts	
Date of Birth of Great-Aunts	
Name of Great-Nephews	
Date of Birth of Great-Nephews	
Name of Great-Nieces	
Date of Birth of Great-Nieces	
Name of Great-Great-Uncles	
Date of Birth of Great-Great-Uncles	
Name of Great-Great-Aunts	
Date of Birth of Great-Great-Aunts	
Name of Great-Great-Nephews	
Date of Birth of Great-Great-Nephews	
Name of Great-Great-Nieces	
Date of Birth of Great-Great-Nieces	
Name of Great-Great-Great-Uncles	
Date of Birth of Great-Great-Great-Uncles	
Name of Great-Great-Great-Aunts	
Date of Birth of Great-Great-Great-Aunts	
Name of Great-Great-Great-Nephews	
Date of Birth of Great-Great-Great-Nephews	
Name of Great-Great-Great-Nieces	
Date of Birth of Great-Great-Great-Nieces	
Name of Great-Great-Great-Great-Uncles	
Date of Birth of Great-Great-Great-Great-Uncles	
Name of Great-Great-Great-Great-Aunts	
Date of Birth of Great-Great-Great-Great-Aunts	
Name of Great-Great-Great-Great-Nephews	
Date of Birth of Great-Great-Great-Great-Nephews	
Name of Great-Great-Great-Great-Nieces	
Date of Birth of Great-Great-Great-Great-Nieces	

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS
No. 1000
Date of Birth
Place of Birth
Sex
Race
Religion
Education
Occupation
Marital Status
Name of Spouse
Date of Marriage
Name of Children
Date of Birth of Children
Name of Parents
Date of Birth of Parents
Name of Grandparents
Date of Birth of Grandparents
Name of Siblings
Date of Birth of Siblings
Name of Uncles
Date of Birth of Uncles
Name of Aunts
Date of Birth of Aunts
Name of Cousins
Date of Birth of Cousins
Name of Nephews
Date of Birth of Nephews
Name of Nieces
Date of Birth of Nieces
Name of Great-Uncles
Date of Birth of Great-Uncles
Name of Great-Aunts
Date of Birth of Great-Aunts
Name of Great-Nephews
Date of Birth of Great-Nephews
Name of Great-Nieces
Date of Birth of Great-Nieces
Name of Great-Great-Uncles
Date of Birth of Great-Great-Uncles
Name of Great-Great-Aunts
Date of Birth of Great-Great-Aunts
Name of Great-Great-Nephews
Date of Birth of Great-Great-Nephews
Name of Great-Great-Nieces
Date of Birth of Great-Great-Nieces
Name of Great-Great-Great-Uncles
Date of Birth of Great-Great-Great-Uncles
Name of Great-Great-Great-Aunts
Date of Birth of Great-Great-Great-Aunts
Name of Great-Great-Great-Nephews
Date of Birth of Great-Great-Great-Nephews
Name of Great-Great-Great-Nieces
Date of Birth of Great-Great-Great-Nieces
Name of Great-Great-Great-Great-Uncles
Date of Birth of Great-Great-Great-Great-Uncles
Name of Great-Great-Great-Great-Aunts
Date of Birth of Great-Great-Great-Great-Aunts
Name of Great-Great-Great-Great-Nephews
Date of Birth of Great-Great-Great-Great-Nephews
Name of Great-Great-Great-Great-Nieces
Date of Birth of Great-Great-Great-Great-Nieces
Name of Great-Great-Great-Great-Great-Uncles
Date of Birth of Great-Great-Great-Great-Great-Uncles
Name of Great-Great-Great-Great-Great-Aunts
Date of Birth of Great-Great-Great-Great-Great-Aunts
Name of Great-Great-Great-Great-Great-Nephews
Date of Birth of Great-Great-Great-Great-Great-Nephews
Name of Great-Great-Great-Great-Great-Nieces
Date of Birth of Great-Great-Great-Great-Great-Nieces

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

3346

03944

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAMASCUS	
c. LENGTH OF STAY IN IB -1 DAY		d. STREET ADDRESS 25119 OAK DRIVE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TIRZAH Middle Grace Last SHOOK		4. DATE OF DEATH Month 3 Day 6 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-91
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 6 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE, RETIRED		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB GROVE		14. MOTHER'S MAIDEN NAME PRISCILLA SOLLENBERGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 182-36-4964	
17. INFORMANT MEDICAL RECORDS DEPT.		Address Richard D. Shook, Damascus, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure - due to Arterio-sclerotic Heart Disease DUE TO (b) 4200 DUE TO (c) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Hours Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Embolus to right brachial artery		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1967 , to 3-6, 1967 , that (I) (we) last saw the deceased alive on 3-6, 1967 , and that death occurred at 1 P. M. from causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher		22b. DATE SIGNED 3-6-67	
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M.D.		22d. ADDRESS RUSSELL AVENUE, GAITHERSBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/9/67	23c. NAME OF CEMETERY OR CREMATORY Whitemarsh Memorial Park - Pikesville, PA.	23d. LOCATION (City or Town) (County) (State) Pikesville, PA.
24. FUNERAL DIRECTOR C.E. Munnich - Greencastle, Pa.		25a. REC'D BY REGISTRAR MAR 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0344

3338

BARBERSHOP

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Handwritten notes and signatures at the bottom of the page, including a large signature on the left and various smaller notes and initials.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

3947

03945

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 8 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 8809 Loenard Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Tzvi Silver		4. DATE OF DEATH March 6 1967	
5. SEX Male		6. COLOR OR RACE Cauc	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 30 1965	
9. AGE (In years lost birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 11 Days 19 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mendel M. Silver		14. MOTHER'S MAIDEN NAME Malka Harendorf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Father		Address Mr. Mendel M. Silver-as above-2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO (b) CEREBRAL ANOXIA DUE TO (c) ACUTE EPIGLOTTITIS		INTERVAL BETWEEN ONSET AND DEATH 8 days 8 1/2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/25 , 19 67 , to 3/6 , 19 67 , that (I) (we) lost saw the deceased alive on 3/5 19 67 , and that death occurred at 3:04 M , from causes and on the date stated above.			
22a. SIGNATURE Dr. George Cohen		22b. DATE SIGNED 3/6/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 9919 Georgia Avenue, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL burial		23b. DATE THEREOF 3/6/67	
23c. NAME OF CEMETERY OR CREMATORY National Cap. Hebrew Cem. Washington, D.C.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR B Banzansky + Son		25a. REC'D BY REGISTRAR 3501-144584N	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 7 1967	

03912

CERTIFICATE OF DEATH

5847

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		1910		1955		New York		Heart Disease		[Signature]		[Signature]	
Occupation		Education		Marital Status		Religion		Usual Residence		Usual Occupation		Usual Residence		Usual Occupation		Usual Residence		Usual Occupation	
Teacher		High School		Married		Catholic		123 Main St		Teacher		123 Main St		Teacher		123 Main St		Teacher	
Date of Death		Time of Death		Place of Death		Cause of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Cause of Death	
1955		10:00 AM		New York		Heart Disease		[Signature]		[Signature]		1955		10:00 AM		New York		Heart Disease	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN AND A REGISTRAR.

03948

CERTIFICATE OF DEATH

03946

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 5 Mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8039 EASTERN AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LILLIE SILVERSTEIN		4. DATE OF DEATH Month 3 Day 25 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-3-91
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HW		10b. KIND OF BUSINESS OR INDUSTRY POLAND, WARSAW	
11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ABRAHAM MEYER		14. MOTHER'S MAIDEN NAME MECHLA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219320241	
17. INFORMANT (DAUGHTER) MILDRED SILVERSTEIN		Address SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRYTHMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY OCCLUSION DUE TO (c) ARTERIOSCLEROSIS			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL VASCULAR ACCIDENT			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 1-3 , 19 67 , to 3-25 , 19 67 , that (1) (we) saw the deceased alive on 3-15 , 19 67 , and that death occurred at 4:30 PM, from causes and on the date stated above			
22a. SIGNATURE Bernard H. Ostrow		22b. DATE SIGNED 3-25-67	
22c. PHYSICIAN'S NAME (Type) BERNARD H. OSTROW		22d. ADDRESS 8107 EASTERN AVE. S.S. MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/26/1967	23c. NAME OF CEMETERY OR CREMATORY ROCKDALE	23d. LOCATION (City or Town) (County) (State) BALTO. MD
24. FUNERAL DIRECTOR SYLOAN S. LEWIS & SON, INC. GARRISON, MD		25a. REC'D BY REGISTRAR DATE MAR 28 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

81250

23250

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03949

CERTIFICATE OF DEATH

03947

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

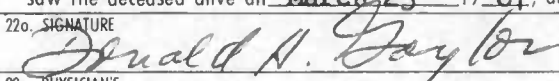
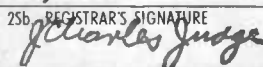
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN TB <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ADELPHI</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. & HOSPITAL</u>				d. STREET ADDRESS <u>1821 ELTON RD.</u>			
3. NAME OF DECEASED (Type or print) <u>ESTHER</u> First <u>NONE</u> Middle <u>SMALL</u> Last			4. DATE OF DEATH Month <u>MARCH</u> Day <u>21</u> Year <u>1967</u>				
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/4/91</u>	9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>HSW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert BURGDOFF</u>				14. MOTHER'S MAIDEN NAME <u>SARAH CASTLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-07-1788-A</u>		17. INFORMANT <u>John Sidus</u> Address <u>1821 Elton Rd. Adelphi, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive heart failure, Uremia</u> DUE TO (b) <u>Hypertensive cardio-vascular disease</u> DUE TO (c) <u>Essential hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>several weeks</u> <u>unknown</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of breast, Uremia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-16</u>, 1967, to <u>3-21</u>, 1967, that (I) (we) last saw the deceased alive on <u>3-21</u>, 1967, and that death occurred at <u>10:15</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Eino Magi</u>				22b. DATE SIGNED <u>3-21-67</u>		22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Mar 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>				24. FUNERAL DIRECTOR <u>Glen Carter</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. ADDRESS <u>4434 Georgia Avenue</u>		25d. DATE <u>MAR 27 1967</u>	
25e. ADDRESS <u>Warner E. Humphrey, Inc.</u>				25f. ADDRESS <u>Silver Spring, Md.</u>			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03950

CERTIFICATE OF DEATH

03948

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)			c. LENGTH OF STAY IN 1b 9 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 2533 Rambling Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kenneth James SMALLMAN			First Middle Last	4. DATE OF DEATH Month March Day 23 Year 19 67			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1959		9. AGE (In years last birthday) 7 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Honolulu, Hawaii		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Smallman				14. MOTHER'S MAIDEN NAME Mary E. Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO.		17. INFORMANT Address John Smallman, 2533 Rambling Road, Vienna, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7540 Tetralogy of Fallot DUE TO (b) Congenital malformation heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 14, 1967 , to March 23, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 23, 1967 , and that death occurred at 215A M, from causes and on the date stated above.							
22a. SIGNATURE  M.D.				22b. DATE SIGNED March 23, 1967			
22c. PHYSICIAN'S NAME (Type) Donald H. Gaylor, M. D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 27, 67	23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Va.		
24. FUNERAL DIRECTOR Falls Church Funeral Home, 1102 West Broad St., Falls Church, Va.				25a. REC'D BY REGISTRAR MAR 27 1967		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(Contd.) Page 2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03951 CERTIFICATE OF DEATH 03949

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON SANITARIUM & HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK. d. STREET ADDRESS 7205 SPRUCE AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LILLIE Middle MAE Last SMITH		4. DATE OF DEATH Month MARCH Day 25 Year 19 67.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1887
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Howard County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Albert Shipley		14. MOTHER'S MAIDEN NAME Mary Ann Holtman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT H. Elmer Shipley, (same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 9, 1967 , to Mar 24, 1967 , that (I) (we) last saw the deceased alive on Mar. 24 1967 , and that death occurred at 12:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Theodore R. Flatz		22b. DATE SIGNED 9/25/67	
22c. PHYSICIAN'S NAME (Type) THEODORE R. FLATZ		22d. ADDRESS 7030 CARROLL AVENUE, Tak Pk. Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 28, 1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Switzland, Pa. Geo. Co. Md.	
24. FUNERAL DIRECTOR J. Arthur Walters		25. REC'D BY REGISTRAR 9 MAR 28 1967	
ADDRESS 254 Carroll St. N.W.D.C.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

03251

Montgomery

TANOMA PARK

WASHINGTON SANITARIUM & HOSPITAL

3255 SPRUCE AVENUE

LIAMIS

SMITH

MARCH

Dec. 11, 1937

REMAINS - WHITE

Housewife

Own Home

Howard County, Md. U.S.A.

Mary Albert Shipley

Mary Ann Holman

H. Elmer Shipley, (same as 2)

THEODORE A. THAX

7080 CARROLL AVENUE, TAK RM. MD.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03952

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03950

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 2 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Nursing Home		e. STREET ADDRESS 14326 New Hampshire Ave.	
3. NAME OF DECEASED (Type or print) MAETIE P. SMITH		4. DATE OF DEATH Month March 1, Day 19 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1874
9. AGE (In years last birthday) yrs. 92		10. IF UNDER 1 YEAR Months 15 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Ferdinand Prahl		14. MOTHER'S MAIDEN NAME Christine Stettner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-62-5056	
17. INFORMANT Son		3227 Tennyson St. Washington, D. C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma metastatic of lungs + abdomen. DUE TO (b) Carcinoma of Rt. Breast. DUE TO (c) 2 Years?		INTERVAL BETWEEN ONSET AND DEATH 2 Years?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		22. DATE SIGNED Mar. 2, 1967	
EXAMINER'S NAME (Type) JOHN G. BALL		23. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3-2-67	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25. REG'D BY REGISTRAR MAR 8 1967	
25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE	

03250

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03250

X X

X

John M. Rife

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

03953

03951

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. In any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d. STREET ADDRESS 4541 45th Street N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle PAULINE Last SMITH		4. DATE OF DEATH Month March Day 30 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years birthdate) yrs. 89		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during previous 12 months, even if retired) Housewife		10b. KIND OF BUSINESS OR OCCUPATION Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give branch or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Ethel Ayers		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden Reap		22. DATE SIGNED 3/30/67	
EXAMINER'S NAME (Type) Belden Reap M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Montgomery	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 4/3/67	
23c. NAME OF CEMETERY OR CREMATORY Greenhill		23d. LOCATION (City or town) (County) (State) Martinsburg West Virginia	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland		25a. REC'D BY REGISTRAR APR 3 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

12020

12020

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03954

CERTIFICATE OF DEATH

03952

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Michigan b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 37 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grant 59.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland			d. STREET ADDRESS No Street Address		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Mildred Elaine Smith			4. DATE OF DEATH Month Day Year March 22 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 March 1908	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse's Aide		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (County & State, or foreign country) Michigan	
13. FATHER'S NAME Al Blood			14. MOTHER'S MAIDEN NAME Claudia Finley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 378-38-6001		17. INFORMANT Address The Medical Records The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blastic crisis DUE TO (b) Chronic myelogenous leukemia DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 1-1/2 months 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that the (this hospital) attended the deceased from 13 Feb. , 1967, to 22 March , 1967, that (I) (we) last saw the deceased alive on 22 March , 1967, and that death occurred at 9:05 PM , from causes and on the date stated above.					
22a. SIGNATURE <i>I. David Goldman</i>			22b. DATE SIGNED 23 March 1967		
22c. PHYSICIAN'S NAME (Type) I. David Goldman, M.D.			22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)		
Burial-transit	3-24-67	Ashland Center Cem.	Ashland Township, Mich.		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland			25a. REC'D BY REGISTRAR DATE MAR 27 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MEDICAL CERTIFICATION

03030

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03955

CERTIFICATE OF DEATH

03953

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>XXXXX Penna.</u> b. COUNTY <u>Philadelphia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>	
c. LENGTH OF STAY IN 1b <u>6 days</u>		d. STREET ADDRESS <u>7222 Glenlock Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SISTERS OF HOLY CROSS HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAUL Luther SMALL</u>		4. DATE OF DEATH Month Day Year <u>3 - 30 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-98</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED BRICKLAYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Const.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>LICKDALE, PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>BENNEVILLE SMALL</u>		14. MOTHER'S MAIDEN NAME <u>AMELIA DIETRICH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WW I</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>JANE A. STURGES</u>		Address <u>4515 CLERMONT PL.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1621 CARCINOMATOSIS</u> DUE TO (b) <u>MEASTATIC CANCER</u> DUE TO (c) <u>Bronchogenic CARCINOMA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>POBULAR PNEUMONIA - DIABETIC HISTORY</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/14</u> , 19 <u>67</u> , to <u>3/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/29</u> , 19 <u>67</u> , and that death occurred at <u>8A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Charles Farwell</u>		22b. DATE SIGNED <u>March 30, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Charles Farwell</u>		22d. ADDRESS <u>11406 Viers Mill Rd. Wheaton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transhumal</u>		23b. DATE THEREOF <u>April 3, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Annville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Annapolis, Annapolis, Md.</u>	
24. FUNERAL DIRECTOR <u>Warner & Humphrey Inc. Clark E. Wisor</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

7030

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03956

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>7 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>10311 Brookmoor Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Lamonte Frederick Sonnemann</u>		4. DATE OF DEATH <u>March 7</u> 19 <u>67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1900</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Construction</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Sonnemann</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Estelle Jasker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Mrs. Lila Sonnemann</u>		Address <u>10311 Brookmoor Drive Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL FAILURE</u> DUE TO <u>BRONCHOGENIC CARCINOMA WITH METASTASES</u> DUE TO <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 DAYS</u> <u>4 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EMPHYSEMA</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JULY, 1963</u> to <u>MARCH 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 7, 1967</u> , and that death occurred at <u>11:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert H. Krichmar</u>		22b. DATE SIGNED <u>MARCH 7 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT H. KRICHMAR</u>		22d. ADDRESS <u>7733 ALASKA AVENUE N.W. WASH. D.C. 20012</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 10 1967</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

7250

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03957

03955

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grove Foundation</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>3505 Randolph Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Southard</u> Last <u>Southard</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1967</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Nov. 12, 1868</u> 98 yrs.		9. AGE (in years last birthday) IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u> IF UNDER 24 HRS. Hours <u>15</u> Min. <u>1</u>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Hall</u>				14. MOTHER'S MAIDEN NAME <u>Mary G. Bayce</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Edward Wright, 3505 Randolph Rd Wheaton</u> Address <u>md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4341</u> DUE TO <u>Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> (c) <u>old age - terminal bronchopneumonia</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis, progressive debility</u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>2-12-64</u> to <u>3-6</u>, 1967, that (I) (we) last saw the deceased alive on <u>3-5</u>, 1967, and that death occurred at <u>6:40</u> P.M. from the causes and on the date stated above.																			
22a. SIGNATURE <u>John R. Spencer</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		22b. DATE SIGNED <u>3-6-67</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN R. SPENCER</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>3-9-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Prospect Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Asbury Park, N. Jersey</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>						25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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3200 lbs

Southard

March 6

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Nov 10

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Edward Thompson

Thompson

3 years

3200 lbs

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Edward Thompson

FOR STATE
HEALTH DEPT.

03958

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03956

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jakoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jakoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7511 Carroll Ave		d. STREET ADDRESS 7511 Carroll Ave.	
3. NAME OF DECEASED (Type or print) Cecil Lonnie Spears, Sr.		4. DATE OF DEATH Month 3 Day 30 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-1-29-12
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 30 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cab Driver		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Everett Spears		14. MOTHER'S MAIDEN NAME Effie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 232-18-2380	
17. INFORMANT LAWRENCE SPEARS		Address ARLINGTON, VA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive heart failure accompanied by DUE TO (b) markedly fatty liver and obesity DUE TO (c) stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED 3/30/1967	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-4-67	23c. NAME OF CEMETERY OR CREMATORY BRANCHLAND CEMETERY	23d. LOCATION (City or Town) (County) (State) HUBBALL W. VA.
24. FUNERAL DIRECTOR LIVES FUNERAL HOME by: Ben E. Rogers, Jr.		25a. REC'D BY REGISTRAR APR 4 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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03257

INTELLIGENCE DIVISION

03253

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page. It appears to be a memorandum or report detailing an investigation or intelligence gathering operation.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #23c & d per telephone from funeral home 3/10/67

03960

CERTIFICATE OF DEATH

03958

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Montgomery</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN lb <u>6 months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>733 Sligo Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARIE Katherine Steink</u>		4. DATE OF DEATH <u>March 6 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 22-1886</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Principal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Public Schools</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred Steink</u>		14. MOTHER'S MAIDEN NAME <u>Clara Jonvenal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>220-44-6360</u>	
17. INFORMANT <u>Miss Elsie Michaelson</u>		Address <u>733 Sligo Avenue Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Cachexia + malnutrition</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>year 1</u> <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>Sept</u> , 1967, to <u>3/6</u> , 1967, that (1) (we) last saw the deceased alive on <u>3/6</u> 1967, and that death occurred at <u>2:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>James R. Coleman MD</u>		22b. DATE SIGNED <u>3/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN M.D.</u>		22d. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) <u>Rockville, Maryland</u> (County) <u>D.C.</u> (State)
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner C. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>	
Address <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03258

00220

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03961

CERTIFICATE OF DEATH

03960

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>48 days</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>			d. STREET ADDRESS <u>Route #2, Box 12</u>		
3. NAME OF DECEASED (Type or print) First <u>Riley</u> Middle <u>(None)</u> Last <u>Stevenson</u>			4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>19 67</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 April 1929</u>		9. AGE (In years last birthday) <u>37</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Stevenson</u>			14. MOTHER'S MAIDEN NAME <u>Louise Curtis</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>1951-1953</u>		16. SOCIAL SECURITY NO. <u>215-26-4117</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. OATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudomonas lung abscess</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hodgkin's Disease</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>8 weeks</u> <u>9 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6 February, 1967</u> , to <u>26 March, 1967</u> , that (I) (we) last saw the deceased alive on <u>26 March, 1967</u> , and that death occurred at <u>9:15 M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Martin H. Cohen</u>		22b. OATH SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> P.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>27 March 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Martin H. Cohen</u>	
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/30/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		23d. LOCATION (City or Town) (County) (State) <u>Princess Anne, Md</u>	
24. FUNERAL DIRECTOR <u>William H. James Jr. Princess Anne, Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03963

CERTIFICATE OF DEATH

03962

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN lb <u>26 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home.</u>				d. STREET ADDRESS <u>1580 East-West Highway.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elleta</u> Middle <u>Jewett</u> Last <u>Stuart</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 22-1887</u>	9. AGE (In years last birthday) yrs. <u>79</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u> Hours <u>67</u> Min.		IF UNDER 24 HRS. Hours <u>67</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Forrester B. Burns-</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wheeler.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>217-30-1089</u>		17. INFORMANT <u>Erma Halliday</u> Address <u>1556 East West Highway Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1750 Congestive Heart Failure 24h</u> DUE TO (b) <u>Widespread carcinoma probably originating in ovary</u> DUE TO (c) <u>in ovary</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, malnutrition etc</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>60</u> , to <u>March 2, 1967</u> , that (I) <u>two</u> last saw the deceased alive on <u>2 March 1967</u> , and that death occurred at <u>3:50 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Ernest F. Harmon</u> M.D.				22b. DATE SIGNED <u>2 March 67</u>		22c. PHYSICIAN'S NAME (Type) <u>Ernest F. Harmon MD 9301 Colasville Rd Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Glen Carter</u> ADDRESS <u>8434 Georgia Avenue</u> <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03883

STATE OF TEXAS

03883

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the State of Texas, this 11th day of June, 1901.

GOVERNOR

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FOR STATE
HEALTH DEPT.

03964

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03963

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSTVILLE 16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSP.		d. STREET ADDRESS 6519 PARKWAY COURT	
3. NAME OF DECEASED (Type or print) EDWARD ELLSWORTH SULLIVAN		4. DATE OF DEATH Month MARCH Day 13 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 31, 1915 31
9. AGE (In years lost birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
10b. KIND OF BUSINESS OR INDUSTRY N.A.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN SULLIVAN		14. MOTHER'S MAIDEN NAME TERESA MENZEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 217-10-5932	
17. INFORMANT MRS. KATHERINE SULLIVAN (WIFE)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound in head with cerebral 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) laceration and exsanguination DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased shot self in head
20c. TIME OF INJURY Month, Day, Year 8:00 Hour 3-13 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Hyattsville		(County) (State) Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 17, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR MAR 17 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03304

03304

RECEIVED 10/13/1954

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03965

03965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN TB 11 hours	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		d. STREET ADDRESS 3721 Kayson Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bullard Middle Maria Last Swenarton		4. DATE OF DEATH Month March Day 15 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-93
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Bullard		14. MOTHER'S MAIDEN NAME Ida Myer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no None		16. SOCIAL SECURITY NO. 220-44-4359	
17. INFORMANT Robert Swenarton Patient's chart		Address 3721 Kayson Street Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralytic ileus DUE TO (b) Colitis stating the underlying cause last. (c) 5711		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelitis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October, 1963 , to 15 March, 1967 , that (I) (we) last saw the deceased alive on 14 March 1967 , and that death occurred at 5:32 AM , from causes and on the date stated above.			
22a. SIGNATURE Seruch T. Kimble		22b. DATE SIGNED 3-15-67	
22c. PHYSICIAN'S NAME (Type) Seruch T. Kimble		22d. ADDRESS 921 Pershing Dr., S. S., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 17, 1967	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR John B. Thomas Warner E. Pumphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR Mar 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
 HEALTH DEPT.

03966

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03965

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		d. STREET ADDRESS <u>733 SLIGO AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MAUDE</u> First <u>Easton</u> Middle <u>THATCHER</u> Last		4. DATE OF DEATH <u>3-24-67</u> Month Day Year	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-79</u> yrs. Month Day Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Easton</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia Hoff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Tom B. Thatcher</u> Address <u>7207 Chestnut St Chevy Chase, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to aspiration of gastric contents</u> DUE TO (b) <u>921.7</u> DUE TO (c) <u>conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased vomited and aspirated gastric contents</u>	
20c. TIME OF INJURY Month, Day, Year <u>1:00</u> Hour <u>3-24</u> 19 <u>67</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		20f. (City or town) (County) (State) <u>Takoma Park Montg Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, & county) <u>3/24/1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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03300

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03967

CERTIFICATE OF DEATH

03968

1. PLACE OF DEATH a. COUNTY <u>Montg.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u>		c. LENGTH OF STAY IN 1b <u>15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>15739 Good Hope Rd.</u>		d. STREET ADDRESS <u>15739 Good Hope Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Thomas</u> Last <u>Spencer</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1885</u>
9. AGE (In years last birthday) yrs. <u>81</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Bond</u>		14. MOTHER'S MAIDEN NAME <u>Amirah Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Janie Dorsey (niece)</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion acute</u> DUE TO <u>arteriosclerotic heart disease</u> (b) <u>Hypertensive heart disease</u> DUE TO <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized atherosclerosis - Large ventricular aneurysm</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (1) (this hospital) attended the deceased from <u>Sept 14, 1964</u> to <u>Mar 15, 1967</u> , that (1) (we) last saw the deceased alive on <u>Feb 3, 1967</u> , and that death occurred at <u>10:30 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>John R. Spencer</u>		22b. DATE SIGNED <u>3-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u>BURTONSVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 18, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Round Oak Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Spencerville Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Sworden</u>		25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03968

03967

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				e. STREET ADDRESS 69-K Ridge Road			
3. NAME OF DECEASED (Type or print) First Richard Middle Shoemaker Last Thomas				4. DATE OF DEATH Month March Day 16 Year 19 67			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1915	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months 16 Days 2	IF UNDER 24 HRS. Hours 16 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chester, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Thomas				14. MOTHER'S MAIDEN NAME Grace Hock			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		18. SOCIAL SECURITY NO. 1934-1956		17. INFORMANT Greenbelt Address Maryland Mrs. Helen G. Thomas, 69K Ridge Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardia arrest-sudden 158X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Extensive lympho carcinomatosis of peritonium DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED 17 March 1967	
EXAMINER'S NAME (Type) John G. Ball, M. D.		Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF March 21, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons 4739 Baltimore Ave., Hyattsville, Md.				25a. REC'D BY REGISTRAR MAR 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

03267

03268

REPORT OF EXAMINER'S CERTIFICATE OF DEATH

Marjorie

Marjorie

Greenfield

Greenfield (Marjorie)

60-11 Ridge Road

Marjorie Greenfield

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Marjorie

Thomas

Spencer

Richard

21

Nov. 13, 1912

Nov. 13, 1912

Nov. 13, 1912

11

Greenfield, Pennsylvania

U. S. Navy

Marjorie Greenfield

Grace Hill

Greenfield

Marjorie

Mrs. Helen G. Thomas, 60-11 Ridge Road

Nov. 13, 1912

Greenfield, Pennsylvania

Explanatory typographic representation of position

John G. Hill, M. D.

John G. Hill, M. D.

Colonel Robert, M.D.

Lincoln Greenfield

Greenfield

Lincoln Greenfield's Son
425 Baltimore Ave., Greenfield, Pa.

MAR 20 1913

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03969

03968

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sudburton</u>		d. STREET ADDRESS <u>6621 Piney Branch Road N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>E.</u> Last <u>Tabb</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/1899</u>
9. AGE (In years last birthday) yrs. <u>67</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Samper</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore M.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morris Tabb</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Brooks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Dr. S. I. Tabb</u>		Address <u>13,000 GA. AVE. S.E. WASH. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Leukemia chr. Myelogenous</u> DUE TO (c) <u>Hypertension Heart Dis.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>13 wks.</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 8, 1967</u> to <u>March 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 8, 1967</u> , and that death occurred at <u>3:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>S. I. Tabb M.D.</u>		22b. DATE SIGNED <u>3/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. I. TABB, M.D.</u>		22d. ADDRESS <u>13,000 GA. AVE. S.E. WASH. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>OXON HILL, MD.</u>
24. FUNERAL DIRECTOR <u>Frederick J. ...</u>		25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>...</u>		25c. REGISTRAR'S NAME <u>...</u>	

03263

UNITED STATES DEPARTMENT OF THE ARMY

03263

Unknown

Victory Bay

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2a, b, c & d Film #G386 3/20/67 pg

03970

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03969

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>2430 Ontario Rd., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Emmett</u> Middle <u>(none)</u> Last <u>Trent</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-80</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>15</u> IF UNDER 24 HRS. Hours <u>15</u> Min. <u>47.3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wales Trent</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Washington Sanitarium & Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4821</u> IMMEDIATE CAUSE (a) <u>Bronchogenic Pneumonia Confluent Ptysing</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Bell</u> M.D.		22. DATE SIGNED <u>3/9/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-12-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL</u>	23d. LOCATION (City or Town) (County) (State) <u>FARMVILLE VIRGINIA</u>
24. FUNERAL DIRECTOR <u>W. ERNEST LARVIS CO.</u>		25a. REC'D BY REGISTRAR <u>1432 YOU STREET N.W.</u> DATE <u>MAR 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
039771						039770					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>MONTGOMERY</u>						a. STATE <u>MD.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>						b. COUNTY <u>1</u>					
c. LENGTH OF STAY IN 1b <u>7 DAYS</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NURSING HOME</u>						d. STREET ADDRESS <u>3652 MALDEN AVE</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED <u>LENA</u> First Middle Last						4. DATE OF DEATH <u>3 - 14 1967</u> Month Day Year					
5. SEX <u>F</u>						6. COLOR OR RACE <u>W</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>3-22-1899</u> 67 yrs.					
9. AGE (In years last birthday) <u>67</u>						10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>JOHN BASSLER</u>						14. MOTHER'S MAIDEN NAME <u>LENA BROWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. <u>215-10-5930-D</u>					
17. INFORMANT <u>GLORIA L. MCGOWAN-LAUREL, MD.</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Thyroid with metastases</u>											
194X DUE TO <u>to metastases in bones</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>March 7, 1967</u> to <u>March 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 12, 1967</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Boris Robkin</u>											
22b. DATE SIGNED <u>3/14/67</u>											
22c. PHYSICIAN'S NAME (Type) <u>BORIS ROBKN</u>											
22d. ADDRESS <u>1019 Univ Blvd EAX</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
23b. DATE THEREOF <u>3/18/67</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Sater's Cemetery</u>											
23d. LOCATION (City, town or county) (State) <u>Balto Co, Md</u>											
24. FUNERAL DIRECTOR <u>Austin E. Donovan</u> ADDRESS <u>3818 Roland Ave</u>											
25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>											
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

MEDICAL CERTIFICATION

03370

03370

11/11/11

Salto, Md.

Salto's Cemetery

2/18/67

Salto

FOR STATE HEALTH DEPT.

03972

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03971

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring (Wheaton)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Howard Johnson Motel</u>		d. STREET ADDRESS <u>11112 Edmonston DR</u>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> First <u>B</u> Middle <u>Udovich</u> Last		4. DATE OF DEATH <u>MARCH 24</u> 19 <u>67</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-21-25</u> 41 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Principal Board of Education</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Joseph Udovich</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gaspertitch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>109-20-8161</u>	
17. INFORMANT <u>Wife</u> Address <u>Same as Item 2.</u>		18. Catherine Udovich	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery heart disease</u> DUE TO (c) <u>100%</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>3/24/1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVALS (Specify) <u>Burned</u>	23b. DATE THEREOF <u>3/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>American Legion Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Princess Anne, Maryland</u>
24. FUNERAL DIRECTOR <u>Robert G. Humphrey</u> Address <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 30 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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100-30-811

100-30-811

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03973

CERTIFICATE OF DEATH

03972

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>24 hrs 40 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baithersburg</u>		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>405 Baithers St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Angelina</u> First Middle Last <u>AKAS</u>				4. DATE OF DEATH <u>MARCH 28</u> Month Day Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>9-24-99</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Kaufman</u>				14. MOTHER'S MAIDEN NAME <u>Rose (Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-40-7396</u>		17. INFORMANT <u>Elfrieda Mitsiliadis (Daughter)</u>		Address <u>See item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBARACHNOID HEMORRHAGE</u> DUE TO (b) <u>ARTERIO SCLEROTIC CEREBRAL-VASCULAR DISEASE</u> DUE TO (c) <u>5 YRS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>26 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA OF THYROID</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT. 15</u> , 19 <u>58</u> , to <u>MARCH 28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MARCH 27</u> , 19 <u>67</u> , and that death occurred at <u>3:40 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert G. Angle</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>MARCH 28, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>				22d. ADDRESS <u>5009 Del Ray Ave. Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-31-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25. REC'D BY REGISTRAR <u>Charles Judge</u>		26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
5130 Wisconsin Ave. N.W., Wash. D.C.				DATE <u>MAR 31 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

37530

THE BUREAU OF HEALTH

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40 NORTH OF VICTORIA "COLUMBIAN" HOTEL, VICTORIA, B.C.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03974

03973

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 mo.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Sanitarium</u>				d. STREET ADDRESS <u>6223 Shadyside Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Stephen DAVID Vaughan</u>				4. DATE OF DEATH <u>MARCH 22 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 18, 1885</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTAINER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Stephen Vaughan</u>				14. MOTHER'S MAIDEN NAME <u>Annie Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-32-5461</u>		17. INFORMANT <u>Mrs. Edw. Schmidt</u> Address <u>Capital Hts., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 334X DUE TO (b) <u>Stasis, varicella, and inactivity</u> DUE TO (c) <u>Generalized and cerebral arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>many months</u> <u>many years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 20, 1967</u> , to <u>March 22, 1967</u> , that (I) (we) lost the deceased alive on <u>3/14 1967</u> , and that death occurred at <u>8:00</u> A.M. from causes on and on the date stated above.							
22a. SIGNATURE <u>George H. Mitchell</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 22 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. George H. Mitchell</u>				22d. ADDRESS <u>11125 Rockville Pike - Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASH. NATIONAL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>PRINCE GEORGES, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>ROBERT E. WILHELM FUNERAL HOME</u> ADDRESS <u>4308 SUITLAND ROAD, SUITLAND, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>DATE R 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS

03374

03374

Know all men by these presents, that [illegible] of the County of Dallas, State of Texas, for and in consideration of the sum of [illegible] Dollars, to [illegible] in hand paid by [illegible], the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said [illegible] of the County of Dallas, State of Texas, all that certain [illegible] of land, situate in the County of Dallas, State of Texas, and more particularly described as follows, to-wit:

[illegible] of the [illegible] of the County of Dallas, State of Texas, containing [illegible] acres, more or less, as the same may appear from the records of the County Clerk of said County, Dallas, Texas, and the same are more particularly described as follows, to-wit:

[illegible] of the [illegible] of the County of Dallas, State of Texas, containing [illegible] acres, more or less, as the same may appear from the records of the County Clerk of said County, Dallas, Texas, and the same are more particularly described as follows, to-wit:

[illegible] of the [illegible] of the County of Dallas, State of Texas, containing [illegible] acres, more or less, as the same may appear from the records of the County Clerk of said County, Dallas, Texas, and the same are more particularly described as follows, to-wit:

[illegible] of the [illegible] of the County of Dallas, State of Texas, containing [illegible] acres, more or less, as the same may appear from the records of the County Clerk of said County, Dallas, Texas, and the same are more particularly described as follows, to-wit:

[illegible] of the [illegible] of the County of Dallas, State of Texas, containing [illegible] acres, more or less, as the same may appear from the records of the County Clerk of said County, Dallas, Texas, and the same are more particularly described as follows, to-wit:

[illegible] of the [illegible] of the County of Dallas, State of Texas, containing [illegible] acres, more or less, as the same may appear from the records of the County Clerk of said County, Dallas, Texas, and the same are more particularly described as follows, to-wit:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

90

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03975

CERTIFICATE OF DEATH

03974

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanatorium</u>				d. STREET ADDRESS <u>8718 Cameron Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clevie</u> Middle <u>Taylor</u> Last <u>Wadford</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov 20 1886</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Frances Kilgore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-547424</u>		17. INFORMANT <u>Katherine Lang</u> Address <u>8201 16th Street Silver Spring, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Cerebral arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1966</u> to <u>Mar 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 13 1967</u> , and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Marvin Wadler</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 13, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>				22d. ADDRESS <u>8218 Wise Av. Bethesda, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>March 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Largo Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Largo, Florida</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>				25. MADE BY REGISTRAR <u>John B. Thomas</u> <u>434 Georgia Avenue</u> <u>Silver Spring, Md</u>		26. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>	

0324

2505

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03976

CERTIFICATE OF DEATH

03975

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u> c. LENGTH OF STAY IN 1b <u>14.2</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington</u>				2. USUAL RESIDENCE (Where deceased lived; if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u> d. STREET ADDRESS <u>911 Sago Creek Parkway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>August J. Waechter</u> First Middle Last				4. DATE OF DEATH <u>March 7, 1967</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/21/1883</u> 83 yrs.	
9. AGE (In years last birthday) <u>83</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Cleveland Ohio</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				13. FATHER'S NAME <u>Leopold A. Waechter</u>			
14. MOTHER'S MAIDEN NAME <u>Emilie Herbst</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>218-16-0519</u>				17. INFORMANT <u>Mary E. Waechter</u> Address <u>(Same as #2 above)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia, Congestive heart failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 22</u> , 19 <u>67</u> , to <u>37</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-7</u> , 19 <u>67</u> , and that death occurred at <u>11:45</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Bene M. Bandler</u>				22b. DATE SIGNED <u>3/7/1967</u>		22c. PHYSICIAN'S NAME (Type) <u>B. G. BENDLER</u>	
22d. ADDRESS <u>10820 Georgia Ave, Wheaton, Md</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>3/11/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodsboro Cemetery, Potomac, Md</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>		23e. REC'D BY REGISTRAR <u>Charles Judge</u>	
23f. REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>Elmer W. Walters</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03977

03976

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RANDOLPH Hills Nursing Home</u>		d. STREET ADDRESS <u>329 Quakenbros ST. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Louis</u> Last <u>Wagman</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 15 1888</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery & Liquor</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>NATURALIZED U.S.</u>	
13. FATHER'S NAME <u>HIRSH Wagman</u>		14. MOTHER'S MAIDEN NAME <u>Baila RichTa</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN -</u>		16. SOCIAL SECURITY NO. <u>577-52-0052</u>	
17. INFORMANT <u>Michel Wagman</u>		Address <u>829 Quakenbros N.W.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic heart disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1) Shigellosis 2) Repeated aspiration pneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , to <u>3/31</u> , 1967, that (I) (we) last saw the deceased alive on <u>3/31</u> , 1967, and that death occurred at <u>2:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Norman H. Rubenstein</u> M.D.		22b. DATE SIGNED <u>3/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>NORMAN H. RUBENSTEIN</u>		22d. ADDRESS <u>11161 N.H. Ave. SILVER SPRING, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NATHAN HECHT CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON D.C.</u>
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>APR 4 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

03976

5250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03978

CERTIFICATE OF DEATH

03977

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>93 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> 15-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Duburbon</u>			d. STREET ADDRESS <u>3600 Cardiff Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Louise</u> First <u>A.</u> Middle (WALES) Last <u>Wicks</u>			4. DATE OF DEATH <u>3-6-1967</u> 19		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-1889</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Michigan-Paginaw</u>	
13. FATHER'S NAME <u>Michael Reseneck</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			14. MOTHER'S MAIDEN NAME <u>Hennetta Lang</u>		
16. SOCIAL SECURITY NO. <u>220-541234</u>			17. INFORMANT <u>Daughter - Mrs. Floyd E. Davis, Jr.</u> Address <u>Same as above</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Primary carcinoma of ovary with widespread</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>abdominal and thoracic metastases.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Broncho-pneumonia</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/3</u> , 19 <u>66</u> , to <u>3/6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/6</u> , 19 <u>67</u> , and that death occurred at <u>10:45</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Luther W. Gray</u>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Dr. Luther W. Gray</u>			22d. ADDRESS <u>1302 18th St., N.W.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>3-8-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Roseland Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Royal Oak, Mich.</u>
24. FUNERAL DIRECTOR <u>Joseph Samuels Son's</u> <u>Livingston D.</u>			25a. REC'D BY REGISTRAR <u>9</u> 1967		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

03977

RECEIVED

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or offending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03979

Item #1c Film #G387 4/3/67 pc

CERTIFICATE OF DEATH

03978

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Kentucky b. COUNTY Kentucky		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maysville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014			d. STREET ADDRESS 400 West 2nd Street		
3. NAME OF DECEASED (Type or print) First Martha Middle Louise Last Walker			4. DATE OF DEATH Month March Day 10 Year 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 October 1918		9. AGE (In years lost birthday) 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John A. Breslin			14. MOTHER'S MAIDEN NAME Martha E. Gaebke		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 293-14-3176	17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of the spleen with / intra-abdominal hemorrhage DUE TO (b) Chronic Myelocytic Leukemia, Blast crisis DUE TO (c) 4 years					INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that 19 (this hospital) attended the deceased from 28 January, 19 67 , to 10 March, 19 67 , that X (we) lost saw the deceased alive on 10 March 19 67 , and that death occurred at 3:00 M , from causes and on the date stated above.					
22a. SIGNATURE I. David Goldman		22b. DATE SIGNED 10 March 1967		22c. PHYSICIAN'S NAME (Type) I. David Goldman, MD	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) 3-14-67	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY St. Gabriel's Cem.	23d. LOCATION (City or Town) Maysville	(County)	(State) KT.
24. FUNERAL DIRECTOR HANLON Funeral Home		25a. REC'D BY REGISTRAR MAR 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

03078

CLIPPER OF 1911

03078

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MD
3
1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03980

CERTIFICATE OF DEATH

03979

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>1400 Kanawha Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Billie</u> Middle <u>Beatrice</u> Last <u>Wall</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>19 67</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 28, 1913</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Brent Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Lulu Fleming</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>579-18-1245</u>	
17. INFORMANT <u>Joseph J. Tychinski</u>		Address <u>11212 Mitscher Street Kensington, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - bronchogenic</u> with <u>metastases to abdomen</u> DUE TO (b) <u>metastases to abdomen</u> DUE TO (c) <u>metastases to abdomen</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Known 6 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <u>March 13, 1967</u> , to <u>March 25, 1967</u> , that (H) (we) last saw the deceased alive on <u>March 25, 1967</u> , and that death occurred at <u>2:24 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Aaron H. Traum</u>		22b. DATE SIGNED <u>March 25 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>		22d. ADDRESS <u>8237 Georgia Ave Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar 28, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03260

FREE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03981

CERTIFICATE OF DEATH

03980

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>2 1/2 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> <u>15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>Colonial Villa Nursing Home</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>(None)</u> Last <u>Wall</u>				4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/28/81</u>		9. AGE (In years last birthday) <u>86</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher - Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>EDUCATION</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u> <u>U.S. America</u>		
13. FATHER'S NAME <u>Isiah Wall</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Strange</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>313-40-3559</u>		17. INFORMANT <u>Medical records</u> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>Metastatic Carcinoma</u> DUE TO <u>Carcinoma of Breast</u> DUE TO <u>Since 1956</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>67</u> , to <u>Mar 22</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>Mar 22</u> , 19 <u>67</u> , and that death occurred at <u>7:50 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Raymond O. West</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3-23-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. DC.</u>				25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13250

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03982

CERTIFICATE OF DEATH

03981

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
c. LENGTH OF STAY IN IB 10 years		d. STREET ADDRESS 2219 - 39th St., N. W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RES MOY SANITARIUM		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATHERINE MARY Waple		4. DATE OF DEATH Month MARCH Day 30 Year 1967	
5. SEX Fe	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9, 1899
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Govt	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM HENRY White		14. MOTHER'S MAIDEN NAME SARAH Benson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-34-6546	
17. INFORMANT Neice		17. ADDRESS 936 Madison St., NW Washington, D. C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive failure 4200 DUE TO (b) arteriosclerotic Heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Disease. DUE TO			INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 24, 1957 , to March 30, 1967 , that (I) (we) last saw the deceased alive on 2/30 1967 , and that death occurred at 6:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE S. W. NEALON Jr.		22b. DATE SIGNED March 29th	
22c. PHYSICIAN'S NAME (Type) S. W. NEALON JR		22d. ADDRESS 1746 K ST N.W. Wash D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Apr. 3, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. RECEIVED BY REGISTRAR APR 3 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner Dr. Ball not signed & cleared. 90

03383

03381

CERTIFICATE OF DEATH

Department of Health

State of New York

County of ...

City of ...

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03983

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03982

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(R) Barnesville</u>				c. LENGTH OF STAY IN TB <u>years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 109</u>				d. STREET ADDRESS <u>Route 109</u>			
3. NAME OF DECEASED (Type or print) First <u>Reginald</u> Middle <u>Eugene</u> Last <u>Ward</u>				4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>May 5, 1914</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charles H. Ward</u>				14. MOTHER'S MAIDEN NAME <u>Addie Bennett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-05-7051</u>		17. INFORMANT <u>Sister Eleanor Ward</u> Address <u>Barnesville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7547</u> <u>Intoxication of cerebral vessels -</u> DUE TO <u>congenital defect of blood vessel</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.				22. DATE SIGNED <u>3/21/67</u>			
EXAMINER'S NAME (Type) <u>John B. Ball</u>				23. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/23/67</u>		23c. LOCATION (City or town) (County) (State) <u>Barnesville Montg Md</u>		23d. REC'D BY REGISTRAR <u>MAR 27 1967</u>	
24. FUNERAL DIRECTOR <u>William C. Hiltz, Barnesville, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

03085

03083

W. J. ...
(R) ...
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Cleared with Dr. J. Ball for Dr. Sterling to sign

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03984

CERTIFICATE OF DEATH

03983

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		d. STREET ADDRESS <u>11502 Elkin Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Forrester Paul Weinstock</u>		4. DATE OF DEATH Month Day Year <u>March 3 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 2, 1907</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK - Delic. Food</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Weinstock</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Zupnik</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-208714</u>	
17. INFORMANT <u>Wife</u>		Address <u>SAME AS D</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 CEREBRAL-VASCULAR HEMORRHAGE</u> DUE TO (b) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE 10 YRS.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 WKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>D, OBSCURE & OLD MYOCARDIAL INFARCTION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>06713</u> , 19 <u>56</u> to <u>3-3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>FEB 27</u> 19 <u>67</u> , and that death occurred at <u>12:40 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Donald Sterling</u>		22b. DATE SIGNED <u>3/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald Sterling, M.D.</u>		22d. ADDRESS <u>352-4th. Bld. WYOMING</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-6-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM. PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>FALLS CHURCH VA</u>	
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>945014</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 7 1967</u>	

03223

RECEIVED

03223

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03985

CERTIFICATE OF DEATH

03985

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1500 Forest Glen Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Weiss</u> Last <u>Weiss</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>m.</u>	6. COLOR OR RACE <u>w.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3.4.88</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Morris Weiss</u>		14. MOTHER'S MAIDEN NAME <u>Laura Dinowitz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Morris Emanuel</u> Address <u>as above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wernia due to bile nephrosis</u> DUE TO (b) <u>Obstructive jaundice</u> DUE TO (c) <u>Carcinoma of head of pancreas</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign prostatic hypertrophy</u>	
21. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 25</u> , 19 <u>67</u> , to <u>March 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar. 30</u> 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Gene U. Cohen M.D.</u>		22b. DATE SIGNED <u>3-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>GENE U. COHEN, M.D.</u>		22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 2, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope Cem. (old)</u>	23d. LOCATION (City or Town) (County) (State) <u>Springfield, L.I. N.Y.</u>
24. FUNERAL DIRECTOR <u>B. Nanyansky & Sons</u>		25. REC'D BY REGISTRAR <u>APR 3 1967</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1983

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

CLEARED BY MEDICAL EXAMINER

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>2309 Ross Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sophie</u> Middle <u>Agnes</u> Last <u>WENDT</u>		4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1905</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Politoski</u>		14. MOTHER'S MAIDEN NAME <u>Anna Baranczok</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>399-14-3480</u>	
17. INFORMANT <u>Patricia Jacoby</u>		Address <u>2309 Ross Road Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBARACHNOID Hemorrhage</u> 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Essential Hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>21 hours</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1965</u> , to <u>MARCH 2, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 2, 1967</u> , and that death occurred at <u>9:47 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Max G. Sherer</u>		22b. DATE SIGNED <u>3/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAX G. SHERER MD</u>		22d. ADDRESS <u>800 PERSHING Drive Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>March 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Adalberts Catholic Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Milwaukee, Wisconsin</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner & Pumphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

03986

CERTIFICATE OF DEATH

03985

03986

03986

2100 Ross Rd
Silver Spring

2100 Ross Rd
Silver Spring

COPIES OF THIS REPORT

MAR 11 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03987

CERTIFICATE OF DEATH

03986

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown R.F.D. 15-1</u>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KATIE</u> Middle <u>A</u> Last <u>WERNER</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 8 - 1896</u>
		9. AGE (In years lost birthday) <u>70</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>German</u>
13. FATHER'S NAME <u>Lorenz Wolf</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>114-18-3866</u>	
		17. INFORMANT <u>Carl Werner, Germanstown Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>34 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>17 Jan</u> , 1967, to <u>31 March</u> 1967, that (I) (we) last saw the deceased alive on <u>30 MARCH</u> 1967, and that death occurred at <u>8:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Fawcett</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>3/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>See Crematorium</u>	23d. LOCATION (City or Town) (County) (State) <u>WASH. D.C.</u>
24. FUNERAL DIRECTOR <u>William B. Wilson, Barnesville, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 4 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

38250

12280

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03988

CERTIFICATE OF DEATH

03987

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>			c. LENGTH OF STAY IN 1b <u>3 months</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			d. STREET ADDRESS <u>Rt #1 Box 433</u>		
3. NAME OF DECEASED (Type or print) <u>Grace - Mildred - West</u>			4. DATE OF DEATH <u>March 1 1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>4/21-1900</u>	9. AGE (In years lost birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Stafford County - Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Richard Good</u>			14. MOTHER'S MAIDEN NAME <u>Julia Ballard</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>577-12-8451</u> <u>579-09-8359</u>	17. INFORMANT <u>Dr. Julian West</u> Address <u>5814 3rd St. NW DC.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute renal failure</u> <u>6000</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to acute and chronic pyelonephritis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 5, 1966</u> to <u>March 1, 1967</u> , that (I) (we) last saw the deceased alive on <u>3/1</u> 19 <u>67</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>John D. Mayloth</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>3/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John D. Mayloth</u>			22d. ADDRESS <u>50 W. Edmonston Dr. Rockville Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3-6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u>		
24. FUNERAL DIRECTOR ADDRESS <u>John T. Rhines & Company -3015 12th St., N. E.</u>			25a. REC'D BY REGISTRAR <u>MAR 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

23280

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03989

CERTIFICATE OF DEATH

03988

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 56 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		d. STREET ADDRESS 7709 Lorton Road	
3. NAME OF DECEASED (Type or print) Israel McKinley Williams		4. DATE OF DEATH Month March Day 13 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1938
9. AGE (In years lost birthday) yrs. 28		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Oil Burner Co.	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bossie Williams		14. MOTHER'S MAIDEN NAME Violet Walters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not Available	
17. INFORMANT The Medical Records		The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2043 IMMEDIATE CAUSE (a) Acute Hemorrhage pneumonitis right lung DUE TO (b) Acute Myelogenous Leukemia DUE TO (c) Peptic Ulcer - 6 months		INTERVAL BETWEEN ONSET AND DEATH 1 day 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peptic Ulcer - 6 months		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from 16 January, 1967 , to 13 March, 1967 , that (A) (we) lost saw the deceased alive on 13 March 1967 , and that death occurred at 8:00 M. from causes on and on the date stated above.			
22a. SIGNATURE Leonard H. Brubaker		22b. DATE SIGNED 13 March 1967	
22c. PHYSICIAN'S NAME (Type) Leonard H. Brubaker, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-16-67	23c. NAME OF CEMETERY OR CREMATORY Prospect Hill	23d. LOCATION (City or Town) (County) (State) Front Royal, Warren Va.
24. FUNERAL DIRECTOR Scott Funeral Home		25. REC'D BY REGISTRAR MAR 16 1967	
25a. ADDRESS Front Royal, Va.		25b. REGISTRAR'S SIGNATURE Charles Judge	

03322

03322

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C. 20250

03322

General

220 Bureau St.

Front Royal, Va.

Prospect Hill

Front Royal, Warren Va.

Front Royal, Va.

Scott Memorial Home

Burial

1-16-57

1-16-57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

4

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03990

CERTIFICATE OF DEATH

03989

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS Hall Shop Rd.	
3. NAME OF DECEASED (Type or print) First Alice Middle Wilson Last Wilson		4. DATE OF DEATH Month Mar. Day 31 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-86
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Allen Peters		14. MOTHER'S MAIDEN NAME Alice Hoffman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-38-8102	
17. INFORMANT Montgomery Gen. Hospital		Address Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO 33IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 WEEK
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from EB. 28, 1967 , to MAR. 31, 1967 , that (I) (we) last saw the deceased alive on 19 , and that death occurred on 2:45am , from causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Charles Whitaker		22d. ADDRESS ELLICOTT CITY, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-3-67	23c. NAME OF CEMETERY OR CREMATORY ST MARKS	23d. LOCATION (City or Town) (County) (State) Highland Md.
24. FUNERAL DIRECTOR Argine Bolton FUN. Home		25a. REC'D BY REGISTRAR APR 3 1967	
ADDRESS ELLICOTT CITY		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03991

03990

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			c. LENGTH OF STAY IN <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u> 13-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rachael</u> Middle <u>Ardell</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>2</u> Year <u>1967</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 23, 1875</u> 9. AGE (In years lost birthday) <u>91</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Horace P. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Wilson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-40-6834 A</u>		17. INFORMANT Address <u>Sheridan Wilson, The Oaks, Ellicott City, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary sclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>46</u> , to <u>3/2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/1</u> , 19 <u>67</u> , and that death occurred at <u>7:15 am</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Charles S. Whitaker</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Charles Whitaker</u>				22d. ADDRESS <u>CLARKSVILLE, M.D.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-4-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>		23d. LOCATION (City or Town) (County) (State) <u>Highland, Md</u>	
24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u> ADDRESS <u>Ellicott City, Md</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03201

CERTIFICATE OF DEATH

03201

DATE OF DEATH

40

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

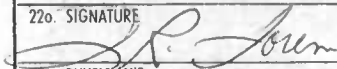
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2a,b,c & d Film #G387 3/28/67 pc

03992

CERTIFICATE OF DEATH

03991

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia Ala. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Naval Hospital				c. LENGTH OF STAY in 1b 164			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Charles WILSON				4. DATE OF DEATH Month Day Year March 10 1967			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Oct 1930		9. AGE (In years lost birthday) yrs. 36	10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps			11b. KIND OF BUSINESS OR INDUSTRY Military		11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Ernest (n) WILSON				14. MOTHER'S MAIDEN NAME Ettalowe WILLIAMS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 417-32-2082		17. INFORMANT Mrs. Louise WILSON			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 4 (this hospital) attended the deceased from 27 Sep 1966 to 10 Mar 67, 19 , that 4 (we) last saw the deceased alive on 10 March 1967 , and that death occurred at 11:45 PM , from causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED 12 March 1967		22c. PHYSICIAN'S NAME (Type) D. R. Foreman M. D.	
22d. ADDRESS Naval Hospital, Bethesda, Md.				22e. REC'D BY REGISTRAR Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE TIME OF 3/16/67		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington Va.	
24. FUNERAL DIRECTOR W.W. Chambers Funeral Home				25. ADDRESS 1400 Chapin St. NW Washington, D.C.			

SEE 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03993

CERTIFICATE OF DEATH

03992

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>26 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Route 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bert Butler Walfrey</u>				4. DATE OF DEATH Month Day Year <u>March 24 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-99</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coca Cola Plant - Silver Spring</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles Wolfrey</u>				14. MOTHER'S MAIDEN NAME <u>Wilmonia Minnick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Walt Army</u>		16. SOCIAL SECURITY NO. <u>577-42-9984</u>		17. INFORMANT <u>Mrs. William J. Wolfrey - 19 MacArthur Drive</u>		Address <u>Bethesda, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Colonic fistula</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 26</u> , 1967, to <u>Mar. 24</u> , 1967, that (I) (we) last saw the deceased alive on <u>Mar. 24</u> , 1967, and that death occurred at <u>7:55 P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Louis R. Perna</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED <u>Mar. 25, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Louis R. PERNA, M.D.</u>				22d. ADDRESS <u>1746 K. ST. N.W. Wash., D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-29-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Beallsville, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

03205

RECEIVED

03205

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs 2 Mos. 4 Days</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>305 Dearborn Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Wolin</u> Last <u>Wolin</u>					4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 25, 1892</u>		9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Wolin</u>					14. MOTHER'S MAIDEN NAME <u>Esther</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>579-10-3936</u>				
17. INFORMANT <u>Nathan Wolin</u>					Address <u>1835 Tulip St., N.W.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1/10, 1967</u> , to <u>3/12, 1967</u> , that (I) (we) last saw the deceased alive on <u>3/7, 1967</u> , and that death occurred at <u>4:30</u> M , from the causes and on the date stated above.									
22a. SIGNATURE <u>Boris Rabkin</u>								22b. DATE SIGNED <u>3/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>					22d. ADDRESS <u>1019 Univ. Blvd East</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>3/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elesavetgrad Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Wash. D.C.</u>		
24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons St. NW, Wash. D.C.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE		

03334

03334

Silver Spring

The Downtown

John

John

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W.D.C.

W.D.C.

U.S. MAR 1 1962

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

03995

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03994

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>2 1/2 Hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9312 Win Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jora</u> Middle <u>Leona</u> Last <u>York</u>		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12-07-59</u>
9. AGE (In years last birthday) <u>7</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>
11. BIRTHPLACE (State or foreign country) <u>Grede County, NC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Dinger</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Klutz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service) <u>Unobtainable</u>	
17. INFORMANT <u>Daughter - Mrs John G. Vicens</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute hemorrhagic pancreatitis</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL <input checked="" type="checkbox"/>		23b. DATE THEREOF <u>March 17, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grede Mem. Park</u>		23d. LOCATION (City or town) (County) (State) <u>Grede County, North Carolina</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. 8434 Ga. Ave. Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		22. DATE SIGNED <u>3/14/1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u> c. LENGTH OF STAY IN 1b <u>15-1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8007 MacArthur Blvd</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u> d. STREET ADDRESS <u>8007 MacArthur Blvd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) <u>FRANCES V. ZELLER</u>		4. DATE OF DEATH <u>3-19-1967</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-19-1882</u>		9. AGE (in years last birthday) <u>84</u> yrs.		10. FINDER 1 YEAR <u>84</u> Months <u>84</u> Days <u>84</u> Hours <u>84</u> Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>				12. CITIZEN OF WHAT COUNTRY?															
13. FATHER'S NAME <u>August Voehl</u>				14. MOTHER'S MAIDEN NAME <u>Hildegard Heider</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>01982. Long Samuel R.D.</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 331X DUE TO (b) <u>Generalized arteriosclerosis with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>hypertension</u> DUE TO (d) <u>years</u>												INTERVAL BETWEEN ONSET AND DEATH <u>3-1 day</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral hemorrhage with</u> <u>negot arm and leg - 2 days</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>3-10-1967</u> to <u>3-18-1967</u> that (I) (we) last saw the deceased alive on <u>3-18-1967</u> and that death occurred at <u>7P</u> M, from the causes and on the date stated above.												22a. SIGNATURE <u>C P Ryland</u>				22b. DATE SIGNED <u>3-19-67</u>				22c. PHYSICIAN'S NAME (Type) <u>C P RYLAND</u>				22d. ADDRESS <u>4400-49 St NW Washington D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>3.22.67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>				23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>															
24. FUNERAL DIRECTOR <u>Lee's Funeral Home</u>				ADDRESS <u>300 4th N.E.</u>				25a. REC'D BY REGISTRAR <u>23 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>															

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